Family Support Gift Card Program

Application Information

Providing support to families affected by pediatric brain cancer is one of Joshua's Great Things missions. We are happy to be able to give families the opportunity to apply for a gift card through our gift card program. Please review the application requirements listed below and complete the Family Support Application, along with required signatures.

Joshua's Great Things will send the requested option based on availability. Applications are reviewed by our Finance Committee approximately every two weeks. If there are any questions, you will be contacted by Joshua's Great Things. We will do our best to honor your request and provide you with the best support to meet your needs.

Family Support Requirements

1. Any family with a child diagnosed with brain cancer prior to the child's 18th birthday or be over 18 and diagnosed at a Children's hospital **and** in active cancer treatment is eligible for consideration.
2. The applicant must be the parent or legal guardian of the diagnosed child and the primary caregiver of the child.
3. All sections of the application must be completed and signatures must be on the form in order for our Finance Committee to review the request. Failure to provide complete information is a basis for denial of an application.
4. Assistance may be requested once each calendar year. Each request for assistance requires submission of a new application.
5. Please contact Rhonda Brown at joshuasgreatthings@gmail.com if you have any questions concerning the application process.

After you complete the application, please return it to your hospital social worker, scan and e-mail, or mail to:

Joshua's Great Things
PO Box 114
O'Fallon, IL 62269
joshuasgreatthings@gmail.com

Joshua's Great Things

Application Date: _____

Family Support Application

Section 1: Patient and Family Information

Patient's Name: _____

Birth Date: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Name of Parent(s)/Guardian(s): _____

How did you hear about our program: ☐ Doctor ☐ Nurse ☐ Social Worker ☐ Family/Friend

Patient's Diagnosis: _____

Date of Diagnosis: _____ Is patient in active cancer treatment ? ☐ Yes ☐ No

Treating Physician Name: _____ Hospital/Clinic: _____

Section 2: Medical Information and Provider Certification

(To be completed by the patient's treating Physician, Social Worker, or designee.)

I certify that the information in the application is true and accurate, to the best of my knowledge.

Health Care Professional Name: _____

Health Care Professional Signature: _____

Section 3: Family Support Options

Families will receive $250 in gift cards. Choose the gift card option(s) that would be most beneficial to your family; *you may choose to have your support split evenly among up to 2 of the following*:

☐ BP Gas	☐ Schnucks	☐ Applebees
☐ Shell Gas	☐ Dierbergs	☐ Pizza Hut
☐ Circle K	☐ Walmart	☐ Chick Fil A
☐ Moto Mart	☐ Target	☐ St Louis Bread Co

Section 4: Parent Signature and Agreement

By signing this form, I attest that the information provided on this form is, to the best of my knowledge, true and accurate. Also, by signing this application I give the medical professionals listed above and Joshua's Great Things permission to discuss medical information about my child's case.

Patient Name: _____

Parent/Guardian Signature: _____ Date:_____